EXHIBIT A

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
	10/01/2007	SINGLETON, CHRISTINE J.		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
940 HARRISON		LINCOLN PARK	MI	48146
8. Employer Name				9. Federal ID No.
United Parcel Services				36-2407381
10. Employer Street Address		11. City	12. State	13. Zip Code
25600 NORTHLINE ROAD		TAYLOR	MI	WAYNE
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
Liberty Mutual Insurance			23043-111	46207
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
471-694863		WAYNE		

23. Reason For Dispute

A. _____ Injury not work related
B. _____ Medical treatment not related to injury
C. _____ Further investigation required (please specify below)
D. _____ Additional information required from employee (please specify below)
E. _____ Vocational rehabilitation dispute only (please specify below)
F. ✓ Other (please specify below)

PER THE INDEPENDENT MEDICAL EXAM OF DR. PAUL DROUILLARD DATED 12/28/07 THE EMPLOYEE IS CAPABLE OF RETURN TO WORK WITH NO RESTRICTIONS AT UPS. THEREFORE, BENEFITS HAVE BEEN TERMINATED.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Comepnsation Act, R408.33(1)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
John Griffith	John Griffith	(800) 752-5832	01/09/2008

NOTICE TO EMPLOYEE

By filing this form, your employer or its workers' compensation insurance company has indicated to the Bureau of Workers' Disability Compensation that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

If you feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may request an informal conference or file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Bureau of Workers' Disability Compensation at one of the offices listed below.

DETROIT
State of Michigan Plaza Building
1200 Sixth Street, 12th Floor
(313) 256-2770

ESCANABA
State Office Building
805 Ludington
(906) 786-2081

FLINT
Bristol West Center
G-1388 West Bristol Road
(810) 760-2819

GRAND RAPIDS
2942 Fuller Street N.E.
(616) 447-2670

KALAMAZOO
4203 West Main
(616) 337-3630

LANSING AREA
2501 Woodlake Circle,
Okemos
(517) 241-9393

MOUNT CLEMENS
10th Floor, Old Country Building
10 N. Main
(810) 463-6577

PONTIAC
NBD Building
28 N. Saginaw, Suite 1310
(810) 334-2497

SAGINAW
State Office Building
411-K East Genesee
(517) 758-1768

TDD in Lansing
(517) 322-5987

BWC-107 (Rev. 2/99) Formerly MDL-1-107
21-CSF-20 R2

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
	02/09/2006	Conforto, Janet M		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
14735 Park		Livonia	MI	48154
8. Employer Name				9. Federal ID No.
United Parcel Service				36-2407381
10. Employer Street Address		11. City	12. State	13. Zip Code
29855 Schoolcraft Rd		Livonia	MI	48150
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
Liberty Mutual Insurance Company			230430111	46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
WC 471-633980				

23. Reason For Dispute

A. _____ Injury not work related
B. _____ Medical treatment not related to injury
C. _____ Further investigation required (please specify below)
D. _____ Additional information required from employee (please specify below)
E. _____ Vocational rehabilitation dispute only (please specify below)
F. ✓ Other (please specify below)

Cutting off wage loss benefits only. Per our ME, she is full duty (09-11-06)

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Authority: Workers' Disability Comepnsation Act, R408.33(1)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
Eileen K Lightcap	Eileen K. Lightcap	(800) 752-5832	09/11/2006

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SEP 18 2006

BWC-107 (Rev 2/99) Formerly MDL-1-107
21-CSF-20 R2

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
	11/01/2005	Didonato, Daniel P		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
18267 Mac Arthur		Redford	MI	48240
8. Employer Name				9. Federal ID No.
United Parcel Service				36-2407381
10. Employer Street Address		11. City	12. State	13. Zip Code
29855 Schoolcraft Rd		Livonia	MI	48150
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
Liberty Mutual Insurance Company			23043011	46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
WC 471-634931				

23. Reason For Dispute

- A. ✓ Injury not work related
- B. _____ Medical treatment not related to injury
- C. _____ Further investigation required (please specify below)
- D. _____ Additional information required from employee (please specify below)
- E. _____ Vocational rehabilitation dispute only (please specify below)
- F. _____ Other (please specify below)

_____

_____

_____

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Authority: Workers' Disability Comepnsation Act, R408.33(1)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
Eileen K Lightcap	Eileen K. Lightcap	(800) 752-5832	03/30/2006

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TDD in Lansing
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BWC-107 (Rev. 2/99) Formerly MDL-1-107
21-CSF-20 R2

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
[redacted]	06/16/2005	MILLER, JOHN E.		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
10555 N COUNTY LINE HWY		MILAN	MI	48160
8. Employer Name				9. Federal ID No.
United Parcel Services				36-2407381
10. Employer Street Address		11. City	12. State	13. Zip Code
540 SOUTH MANSFIELD ST.		YPSILANTI	MI	48197
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
Liberty Mutual Insurance			23043-111	46207
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
471-609205		WASHTENAW		

23. Reason For Dispute

A. _____ Injury not work related
B. _____ Medical treatment not related to injury
C. _____ Further investigation required (please specify below)
D. _____ Additional information required from employee (please specify below)
E. _____ Vocational rehabilitation dispute only (please specify below)
F. ✓ Other (please specify below)

PER THE IME OF DR. DROUILLARD THE EMPLOYEE IS NO LONGER DISABLED FROM HIS JOB AT UPS AND MAY RETURN TO UNRESTRICTED DUTY. THEREFORE, BENEFITS HAVE BEENS SUSPENDED BASED ON THIS EXAMINATION.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

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Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

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24. Preparer Name (Please print)	25. Signature	26. Telephone No	27. Date
John Griffith	John Griffith	(800) 752-5832	10/19/2005

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